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CENTERS FOR MEDICARE & MEDICAID SERVICES

Acentra HEALTH

Annual Medical Review Services

Review Report

Reporting Year 2024

BFCC-QIO 13TH SOW
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Region 10:
AK - ID - OR - WA

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BFCC-QIO ANNUAL MEDICAL REVIEW SERVICES REVIEW REPORT REPORTING YEAR 2024

REGION 10

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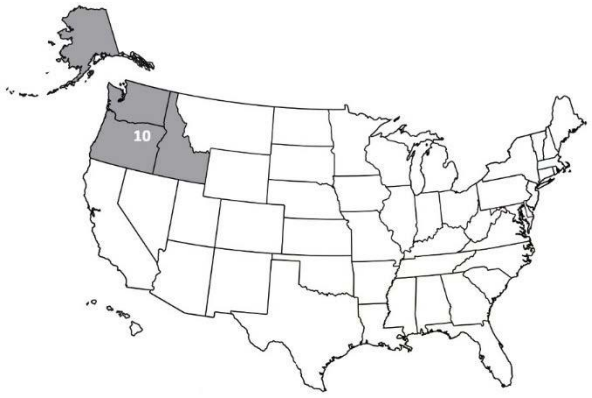
INTRODUCTION

Acentra Health is the designated Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO) for Region 10, which includes: Alaska, Idaho, Oregon, and Washington. Under its contract with CMS, Acentra Health performs critical functions on behalf of Medicare beneficiaries, their families, providers, and CMS itself. The QIO Program is one of the largest federal programs dedicated to improving health quality and is a cornerstone of the U.S. Department of Health and Human Services' National Quality Strategy. The program's goal is to provide better care outcomes and overall health while assisting in lowering costs.



The QIO Program's mission is to improve the effectiveness, efficiency, economy, and quality of services delivered to Medicare beneficiaries. CMS has identified three core functions that guide the work of BFCC-QIOs such as Acentra Health:

- Improving the quality of care for beneficiaries.
- Protecting the integrity of the Medicare Trust Fund by ensuring Medicare pays only for services and goods that are reasonable, necessary, and provided in the most appropriate setting.
- Safeguarding beneficiaries by promptly addressing individual complaints, including Quality of Care concerns, provider-based notice appeals, violations of the Emergency Medical Treatment and Labor Act (EMTALA), and other related matters as defined in QIO-related law.

As a BFCC-QIO, Acentra Health conducts reviews of complaints about the quality of medical care received by beneficiaries. The organization also provides an appeal process for Medicare beneficiaries who are being discharged from hospitals or whose services are being terminated – such as care provided by skilled nursing facilities, home health agencies, hospices, and rehabilitation settings.

To help resolve concerns rapidly, Acentra Health offers a service called Immediate Advocacy, which allows beneficiaries to work with healthcare providers to resolve issues quickly and without requiring a formal review of medical records. These services are designed to protect the rights of beneficiaries while promoting responsiveness and fairness in the healthcare system.

In addition to beneficiary appeals and complaints, Acentra Health performs other mandatory reviews, such as EMTALA reviews and general quality reviews referred by a variety of state and federal agencies and organizations. This review work supports CMS's goals of quality improvement and program integrity while ensuring consistency in decision-making and consideration of local needs.

Understanding individual medical rights and healthcare literacy are central to Acentra Health's approach to protecting beneficiaries and ensuring access to quality care. Through targeted outreach and a commitment to addressing barriers, Acentra Health works to improve access to quality care and promote positive healthcare outcomes.

As part of its reporting responsibilities, Acentra Health provides data on case reviews and other services completed within the designated time period. These reports present both regional information in the report body and state-specific data in the appendix – reflecting the organization's commitment to transparency and accountability. By aligning its operations with CMS's goals and focusing on effective, patient-centered processes, Acentra Health plays a vital role in improving healthcare quality, protecting beneficiaries, and ensuring Medicare resources are used wisely.

ANNUAL REPORT BODY

1) TOTAL NUMBER OF REVIEWS

Review Type	Number of Reviews	Percent of Total Reviews
Acute Appeals, FFS & Managed Care	2,119	12.09%
Medicare FFS Post-Acute Appeals	1,309	7.47%
Medicare Advantage Post-Acute Appeals	13,210	75.34%
Hospital Issued Notice of Non-Coverage Appeals	51	0.29%
Hospital Requested Review Appeals	48	0.27%
Quality of Care	181	1.03%
Immediate Advocacy	540	3.08%
EMTALA	76	0.43%
Total	**17,534**	**100.00%**

2) TOP 10 PRINCIPAL MEDICAL DIAGNOSES

Top 10 Medical Diagnoses	Number of Beneficiaries	Percent of Beneficiaries
1. A419 – Sepsis, unspecific organism	7,899	32.12%
2. I110 – Hypertensive heart disease with heart failure	2,191	8.91%
3. N179 – Acute kidney failure, unspecified	2,184	8.88%
4. I130 – Hypertensive heart and chronic kidney disease with heart failure and Stage 1-4 chronic kidney disease or unspecified chronic kidney disease	2,156	8.77%
5. I214 – Non-ST elevation myocardial infarction	2,142	8.71%
6. U071 – COVID-19	1,894	7.70%
7. J189 – Pneumonia, unspecific organism	1,879	7.64%
8. J9601 – Acute respiratory failure with hypoxia	1,566	6.37%
9. N390 – Urinary tract infection, site not specified	1,461	5.94%
10. I480 – Paroxysmal atrial fibrillation	1,223	4.97%
Total	**24,595**	**100.00%**

3) PROVIDER REVIEWS SETTINGS

Setting	Number of Providers	Percent of Providers
0: Acute Care Unit of an Inpatient Facility	2,008	11.62%
1: Distinct Psychiatric Facility	25	0.14%
2: Distinct Rehabilitation Facility	106	0.61%
3: Distinct Skilled Nursing Facility	14,422	83.46%
5: Clinic	0	
6: Distinct Dialysis Center Facility	0	
7: Dialysis Center Unit of Inpatient Facility	0	
8: Independent-Based Rural Health Clinic	3	0.02%
9: Provider-Based Rural Health Clinic	1	0.01%
C: Freestanding Ambulatory Surgery Center	2	0.01%
G: End-Stage Renal Disease Unit	1	0.01%
H: Home Health Agency	182	1.05%
N: Critical Access Hospital	212	1.23%
O: Setting Does Not Fit Into Any Other Existing Setting Code	86	0.50%
Q: Long-Term Care Facility	8	0.05%
R: Hospice	77	0.45%
S: Psychiatric Unit of an Inpatient Facility	0	
T: Rehabilitation Unit of an Inpatient Facility	28	0.16%
U: Swing Bed Hospital Designation for Short-Term, Long-Term Care, and Rehabilitation Hospitals	0	
Y: Federally Qualified Health Centers	0	
Z: Swing Bed Designation for Critical Access Hospitals	32	0.19%
Other	88	0.51%
Total	**17,281**	**100.00%**

4) QUALITY OF CARE CONCERNS CONFIRMED

A Quality of Care review is conducted by the BFCC-QIO to determine whether the quality of services provided to beneficiaries was consistent with professionally recognized standards of health care. A Quality of Care review can either be initiated by a Medicare beneficiary or his/her appointed representative or referred to the BFCC-QIO from another agency such as the Office of Medicare Ombudsmen and/or Congress, etc.

Acentra Health, in keeping with CMS directions, has referred all confirmed Quality of Care concerns, which appear to be systemic in nature and appropriate for quality improvement activities, to the appropriate Quality Innovation Network QIO (QIN-QIO) for follow-up. For confirmed concerns that may be amenable to a different approach to health care or related documentation, Acentra Health retained those concerns and worked directly with the health care provider and/or practitioner. The data below reflects the total number of concerns referred to the QIN-QIO and not those retained by Acentra Health in order to provide technical assistance.

Quality of Care ("C" Category) QRD Category Codes	Number of Concerns	Number of Concerns Confirmed	Percent Confirmed Concerns
C01: Apparently did not obtain pertinent history and/or findings from an examination	2	0	0.00%
C02: Apparently did not make appropriate diagnoses and/or assessments	18	6	33.33%
C03: Apparently did not establish and/or develop an appropriate treatment plan for a defined problem or diagnosis which prompted this episode of care [excludes laboratory and/or imaging (see C06 or C09), procedures (see C07 or C08) and consultations (see C13 and C14)]	109	18	16.51%
C04: Apparently did not carry out an established plan in a competent and/or timely fashion	58	8	13.79%
C05: Apparently did not appropriately assess and/or act on changes in clinical/other status results	4	0	0.00%
C06: Apparently did not appropriately assess and/or act on laboratory tests or imaging study results	3	0	0.00%
C07: Apparently did not establish adequate clinical justification for a procedure which carries patient risk and was performed	7	0	0.00%
C08: Apparently did not perform a procedure that was indicated (other than lab and imaging, see C09)	7	2	28.57%
C09: Apparently did not obtain appropriate laboratory tests and/or imaging studies	2	2	100.00%
C10: Apparently did not develop and initiate appropriate discharge, follow-up, and/or rehabilitation plans	14	5	35.71%
C11: Apparently did not demonstrate that the patient was ready for discharge	24	3	12.50%
C12: Apparently did not provide appropriate personnel and/or resources	0	0	0.00%
C13: Apparently did not order appropriate specialty consultations	2	0	0.00%
C14: Apparently specialty consultation process was not completed in a timely manner	1	1	100.00%
C15: Apparently did not effectively coordinate across disciplines	5	0	0.00%
C16: Apparently did not ensure a safe environment (medication errors, falls, pressure ulcers, transfusion reactions, nosocomial infection)	28	7	25.00%
C17: Apparently did not order/follow evidence-based practices	3	1	33.33%
C18: Apparently did not provide medical record documentation that impacts patient care	4	3	75.00%
C40: Apparently did not follow up on patient's non-compliance	0	0	0.00%
C99: Other quality concern not elsewhere classified	19	3	15.79%
Total	**310**	**59**	**19.03%**

5) Beneficiary Appeals of Provider Discharge/Service Terminations and Denials of Hospital Admissions Outcomes by Notification Type

Appeal Review by Notification Type	Number of Reviews	Physician Reviewer Disagreed with Discharge (%)	Physician Reviewer Agreed with Discharge (%)
Acute Appeals, FFS & Managed Care	2,119	11.04%	88.96%
Medicare FFS Post-Acute Appeals	1,309	44.31%	55.69%
Medicare Advantage Post-Acute Appeals	13,210	49.85%	50.15%
Hospital Issued Notice of Non-Coverage Appeals	51	39.22%	60.78%
Hospital Requested Review Appeals	48	37.50%	62.50%
Total	**16,737**	**44.43%**	**55.57%**

6) Evidence Used in Decision-Making

The table that follows describes the common types of evidence or standard of care used to support Acentra Health Review Coordinators and independent Peer Reviewer decisions for Appeals. For the Quality of Care reviews, we have provided the most highly utilized types of evidence/standards of care to support Acentra Health's Review Coordinator and independent Peer Reviewer decisions for the specific list of diagnostic categories provided in the table.

Review Type	Diagnostic Categories	Evidence/ Standards of Care Used	Rationale for Evidence/Standard of Care Selected
Quality of Care	Pneumonia	UpToDate (*uptodate.com*); Centers for Disease Control and Prevention (CDC) (*cdc.org*); American Medical Association (AMA) (*ama-assn.org*); American Lung Association (*lung.org*)	UpToDate provides standards of care relevant to the concern. The standards are updated as new information is obtained. The CDC is also used as an official resource for accessing guidelines and clinical standards, including detailed treatment regimens and follow-up.
	Heart Failure	UpToDate (*uptodate.com*); American Heart Association (AHA) (*heart.org*); AMA (*www.ama-assn.org*)	UpToDate is used for updated information on current standards of care. AHA and AMA information is used to supplement clinical information.
	Pressure Ulcers	UpToDate (*uptodate.com*); Agency for Healthcare Research and Quality (AHRQ) (ahrq.gov);	UpToDate and AHRQ remain excellent online resources for identifying standards of care and practice guidelines. WOCN provides nursing guidelines for staging and care of pressure ulcers.

Review Type	Diagnostic Categories	Evidence/ Standards of Care Used	Rationale for Evidence/Standard of Care Selected
		Wound, Ostomy and Continence Nursing Society (WOCN) (*WOCN.org*)	
	Acute Myocardial Infarction	UpToDate (*uptodate.com*); AHA (*heart.org*); AMA (*www.ama-assn.org*)	UpToDate is used for updated information on current standards of care. AHA and AMA information are used to supplement clinical information.
	Urinary Tract Infection	UpToDate (*uptodate.com*); American Society of Nephrology (*asn-online.org*)	UpToDate and the American Society of Nephrology provide current standards for renal-related concerns and care.
	Sepsis	UpToDate (*uptodate.com*); Sepsis Alliance (*sepsis.org*); AMA (*ama-assn.org)*	UpToDate provides current standards of care related to the treatment of sepsis. Additional references provide further information for review.
	Adverse Drug Events	UpToDate (*uptodate.com*); CDC (*cdc.gov*); National Institutes of Health (NIH); (*ncbi.nim.hih.gov*); AHRQ *(ahrq.gov)*	UpToDate provides current standards of care. The CDC, NIH, and AHRQ provide additional references related to specific medications and interactions/ reactions associated with the medications.
	Falls	UpToDate (*uptodate.com*); American Geriatrics Society (*americangeriatrics.org*)	UpToDate provides current standards of care to prevent falls. The Geriatric Society provides additional information on preventing falls in the elderly population as well as follow-up treatments.
	Surgical Complications	UpToDate (*uptodate.com*); American College of Surgeons (*facs.org*); NIH (*ncbi.nim.nih.gov*)	UpToDate provides current standards of care related to various surgical procedures. The American College of Surgeons and NIH provide additional insights into various procedures, potential complications (expected and unexpected), and follow-up care.
Appeals		Appeals National Coverage Determination Guidelines, including language and provisions from the JIMMO v. Sebelius settlement	Medicare coverage is limited to services that are: • Reasonable and necessary for the diagnosis or treatment of an illness or injury • Within the scope of a defined Medicare benefit category

Review Type	Diagnostic Categories	Evidence/ Standards of Care Used	Rationale for Evidence/Standard of Care Selected
			• Consistent with professionally recognized standards of care • Appropriately delivered in the most suitable and safe setting.

7) BY GEOGRAPHIC AREA

Table 7A: Appeal Reviews by Geographic Area – Urban and Rural

Geographic Area	Number of Providers	Percent of Providers in Service Area
Urban	16,071	92.57%
Rural	312	1.80%
Unknown	978	5.63%
Total	**17,361**	**100.00%**

Table 7B: Quality of Care Reviews by Geographic Area – Urban and Rural

Geographic Area	Number of Providers	Percent of Providers in Service Area
Urban	238	65.75%
Rural	20	5.52%
Unknown	104	28.73%
Total	**362**	**100.00%**

8) OUTREACH AND COLLABORATION WITH BENEFICIARIES

Strengthening Outreach Through Strategic Stakeholder Engagement

Building strong relationships with diverse stakeholder organizations is a central part of Acentra Health's outreach strategy. Across the regions it serves, Acentra Health actively cultivates and sustains professional partnerships that help extend the reach and impact of the BFCC-QIO program. Whether through one-on-one calls or structured virtual meetings, its direct engagement approach ensures timely and effective communication of program information and updates to stakeholders who serve Medicare beneficiaries.

Acentra Health continues to maintain a productive, collaborative relationship with CMS's Seatle Region 10 office. It regularly shares BFCC-QIO updates, participates in quarterly/annual meetings, and collaborates through joint conference calls with our shared audiences. During the 2024 Medicare open enrollment period, the Outreach team co-hosted multiple webinars with CMS's Region 10 staff, targeting a wide array of healthcare associations in the four states. In addition, Acentra Health and CMS staff partnered through social media by producing a podcast series with episodes featuring speakers from the Region 10 office. They covered topics such as the Medicare Savings Program and various aspects of Medicare titled "Medicare 101."

Webinars took place at the Washington Long-Term Care Ombudsman quarterly meeting to engage long-term care advocates and professionals who aid more than 3,500 Medicare recipients in the state. Targeted outreach to

disparate populations in rural areas included a presentation on Acentra Health's services for the Oregon Area Agencies on Aging. It was directed at staff and volunteers primarily serving rural populations statewide, reaching approximately 7,200 Medicare beneficiaries.

The Outreach team shared information with medical societies representing the rural and underserved populations in Alaska and Washington. Those efforts reached an estimated 12,000 Medicare recipients under the care of physicians from those states.

Multi-Channel Communication and Content Distribution

Outreach and communications efforts at Acentra Health employ multiple channels to inform stakeholders and beneficiaries about the BFCC-QIO program. These include:

- Newsletters – Acentra Health produces two newsletters: "Case Review Connections," a quarterly publication for providers and stakeholders, and "On the Healthcare Front," a monthly publication for beneficiaries. Combined, they reach more than 6,500 subscribers. The stakeholder newsletter has received a Gold MarCom Award and consistently exceeds industry open rate benchmarks.
- Video and Audio Platforms – Acentra Health maintains a YouTube channel and produces the podcast "Aging Health Matters" to broaden outreach to the Medicare population. The Case Status Tool video averages about 700 views per month and leads visitors to an interactive web page that draws more than 300,000 visits per month. Spanish-language videos are available to support the Spanish-speaking population. The podcast has surpassed 1,000 downloads and features guest experts discussing Medicare-related topics.
- Website and Accessibility – The Acentra Health website includes dedicated sections for beneficiaries, offering downloadable resources and program tools available in multiple languages via a page translator and several areas of Spanish-specific web content. The website is continuously monitored for compliance with Section 508 of the Americans with Disabilities Act to ensure accessibility for users with disabilities. A downloadable screen reader is available to support inclusive access.

9) IMMEDIATE ADVOCACY CASES

Number of Beneficiary Complaints	Number of Immediate Advocacy Cases	Percent of Total Beneficiary Complaints Resolved by Immediate Advocacy
604	524	86.75%

10) EXAMPLE/SUCCESS STORY

A Medicare beneficiary contacted Acentra Health while hospitalized, expressing concerns related to her ongoing appeal process and several care-related challenges during her stay. She reported her call bell was not being answered, and a nurse had failed to communicate her requests to the assigned aide, leaving her without the support she needed. She also expressed significant discomfort due to constipation, saying she could not produce more than a small bowel movement and felt great physical distress. Although she requested

medication, she reported that a nurse told her it could not be provided. She requested assistance from Acentra Health to resolve the concerns.

At the beneficiary's request, the Clinical Reviewer (CR) initiated a conference call with the beneficiary's nurse to review all concerns. The nurse responded that medication had been administered 30-60 minutes prior under an "as needed" order, and she previously explained to the beneficiary it could take a few days for a resolution. She also committed to investigating the aide communication issue, promising to straighten it out by checking with the nursing station. Before ending the call, the nurse thanked the CR and the beneficiary. The beneficiary remained on the line and expressed satisfaction with the resolution and appreciation for the advocacy provided by Acentra Health.

11) Beneficiary Demographics

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Sex/Gender		
Female	11,715	63.17%
Male	6,831	36.83%
Unknown	0	0.00%
Total	**18,546**	**100.00%**
Race		
Asian	212	1.14%
Black	450	2.43%
Hispanic	133	0.72%
North American Native	173	0.93%
Other	176	0.95%
Unknown	126	0.68%
White	17,276	93.15%
Total	**18,546**	**100.00%**
Age		
Under 65	2,250	12.13%
65-70	2,240	12.08%
71-80	5,861	31.60%
81-90	6,042	32.58%
91+	2,153	11.61%
Total	**18,546**	**100.00%**

12) Beneficiary Helpline Statistics

Beneficiary Helpline Report	Total Per Category
Total Number of Calls Received	39,478
Total Number of Calls Answered	38,600
Total Number of Abandoned Calls	644
Average Length of Call Wait Times	00:00:33
Number of Calls Transferred by 1-800-Medicare	435

CONCLUSION

Acentra Health's outcomes and findings for this reporting period reflect the daily work performed to improve the quality of care delivered to Medicare beneficiaries. These case reviews not only support each beneficiary's experience and rights but also generate valuable data that can be used to enhance provider performance system-wide. Individual case insights help identify patterns and opportunities for broader quality improvement across the Medicare landscape. In addition, the data presented in this report reveal that most Quality of Care reviews are initiated by concerns raised directly by beneficiaries or their representatives. This reinforces the central role that patient voices play in shaping the review process and driving significant improvements in care.

Acentra Health brings meaningful value to the Medicare program, its beneficiaries, their families and caregivers, and the healthcare providers who serve them. With a strong focus on safeguarding the rights of beneficiaries, Acentra Health partners with healthcare organizations to deliver education about quality standards, medically necessary care, and Medicare compliance. Its services support patients throughout the continuum of care; from early discharge concerns to urgent appeals and communication challenges.

- The complaints and appeals processes Acentra Health offers ensure beneficiaries have access to compassionate, expert advocates who listen and communicate the unique needs of each individual to providers. These concerns are addressed using nationally recognized care standards, helping providers enhance the quality of care delivered to future patients.
- The Immediate Advocacy program provides rapid, real-time solutions to healthcare concerns, often resolving communication breakdowns, language barriers, logistical issues, or challenges with access to equipment or services.
- When a concern about quality of care is confirmed through a medical record review, Acentra Health provides educational feedback to the provider, explaining how similar situations can be improved in the future. If a broader, systemic issue is identified, the case may be referred to the state's QIN-QIO for further support. These organizations provide technical assistance and may initiate a Quality Improvement Initiative to address the root cause of the issue.
- Acentra Health protects both Medicare beneficiaries and the Medicare Trust Fund by ensuring payments are made only for healthcare services that are reasonable, medically necessary, and delivered in the most appropriate setting.
- Acentra Health provides timely and clinically sound physician opinions for required 5- and 60-day reviews under Section 1867(d)(3) of EMTALA for potential violations, helping ensure emergency care standards are upheld.
- Through direct engagement with beneficiaries, families, providers, and community stakeholders, Acentra Health promotes patient-centered care and supports CMS's goals for equitable, high-quality healthcare. Educational outreach and engagement efforts are designed to empower beneficiaries to understand their rights, advocate for themselves, and make informed decisions about their care – regardless of geographic location, language, ability, or other barriers.

Acentra Health incorporates CMS's strategic goals throughout its operations. The work is essential to the Medicare program and makes a lasting impact on the lives of beneficiaries, caregivers, and families. By combining advocacy, education, review services, and a commitment to health equality, Acentra Health ensures quality healthcare is both protected and improved for those it serves.

APPENDIX

ACENTRA BFCC-QIO REGION 10 – STATE OF ALASKA

1) TOTAL NUMBER OF REVIEWS

Review Type	Number of Reviews	Percent of Total Reviews
Acute Appeals, FFS & Managed Care	76	69.09%
Medicare FFS Post-Acute Appeals	11	10.00%
Medicare Advantage Post-Acute Appeals	5	4.55%
Hospital Issued Notice of Non-Coverage Appeals	0	0.00%
Hospital Requested Review Appeals	1	0.91%
Quality of Care	3	2.73%
Immediate Advocacy	12	10.91%
EMTALA	2	1.82%
Total	**110**	**100.00%**

2) BENEFICIARY DEMOGRAPHICS

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Sex/Gender		
Female	304	53.15%
Male	268	46.85%
Unknown	0	0.00%
Total	**572**	**100.00%**
Race		
Asian	33	5.77%
Black	70	12.24%
Hispanic	6	1.05%
North American Native	31	5.42%
Other	10	1.75%
Unknown	2	0.35%
White	420	73.43%
Total	**572**	**100.00%**
Age		
Under 65	90	15.73%
65-70	80	13.99%
71-80	202	35.31%
81-90	157	27.45%
91+	43	7.52%
Total	**572**	**100.00%**

3) PROVIDER REVIEWS SETTINGS

Setting	Number of Providers	Percent of Providers
0: Acute Care Unit of an Inpatient Facility	63	77.78%
1: Distinct Psychiatric Facility	0	0.00%
2: Distinct Rehabilitation Facility	0	0.00%
3: Distinct Skilled Nursing Facility	10	12.35%
5: Clinic	0	0.00%
6: Distinct Dialysis Center Facility	0	0.00%
7: Dialysis Center Unit of Inpatient Facility	0	0.00%
8: Independent-Based Rural Health Clinic	0	0.00%
9: Provider-Based Rural Health Clinic	0	0.00%
C: Freestanding Ambulatory Surgery Center	0	0.00%
G: End-Stage Renal Disease Unit	0	0.00%
H: Home Health Agency	0	0.00%
N: Critical Access Hospital	4	4.94%
O: Setting Does Not Fit Into Any Other Existing Setting Code	0	0.00%
Q: Long-Term Care Facility	1	1.23%
R: Hospice	3	3.70%
S: Psychiatric Unit of an Inpatient Facility	0	0.00%
T: Rehabilitation Unit of an Inpatient Facility	0	0.00%
U: Swing Bed Hospital Designation for Short-Term, Long-Term Care, and Rehabilitation Hospitals	0	0.00%
Y: Federally Qualified Health Centers	0	0.00%
Z: Swing Bed Designation for Critical Access Hospitals	0	0.00%
Other	0	0.00%
Total	**81**	**100.00%**

4) QUALITY OF CARE CONCERNS CONFIRMED

A Quality of Care review is conducted by the BFCC-QIO to determine whether the quality of services provided to beneficiaries was consistent with professionally recognized standards of health care. A Quality of Care review can either be initiated by a Medicare beneficiary or his/her appointed representative or referred to the BFCC-QIO from another agency such as the Office of Medicare Ombudsmen and/or Congress, etc.

Acentra Health, in keeping with CMS directions, has referred all confirmed Quality of Care concerns, which appear to be systemic in nature and appropriate for quality improvement activities, to the appropriate Quality Innovation Network QIO (QIN-QIO) for follow-up. For confirmed concerns that may be amenable to a different approach to health care or related documentation, Acentra Health retained those concerns and worked directly with the health care provider and/or practitioner. The data below reflects the total number of concerns referred to the QIN-QIO and not those retained by Acentra Health in order to provide technical assistance.

Quality of Care ("C" Category) QRD Category Codes	Number of Concerns	Number of Concerns Confirmed	Percent Confirmed Concerns
C01: Apparently did not obtain pertinent history and/or findings from an examination	0	0	0.00%
C02: Apparently did not make appropriate diagnoses and/or assessments	0	0	0.00%
C03: Apparently did not establish and/or develop an appropriate treatment plan for a defined problem or diagnosis which prompted this episode of care [excludes laboratory and/or imaging (see C06 or C09), procedures (see C07 or C08) and consultations (see C13 and C14)]	1	0	0.00%
C04: Apparently did not carry out an established plan in a competent and/or timely fashion	0	0	0.00%
C05: Apparently did not appropriately assess and/or act on changes in clinical/other status results	0	0	0.00%
C06: Apparently did not appropriately assess and/or act on laboratory tests or imaging study results	0	0	0.00%
C07: Apparently did not establish adequate clinical justification for a procedure which carries patient risk and was performed	0	0	0.00%
C08: Apparently did not perform a procedure that was indicated (other than lab and imaging, see C09)	0	0	0.00%
C09: Apparently did not obtain appropriate laboratory tests and/or imaging studies	0	0	0.00%
C10: Apparently did not develop and initiate appropriate discharge, follow-up, and/or rehabilitation plans	2	1	50.00%
C11: Apparently did not demonstrate that the patient was ready for discharge	0	0	0.00%
C12: Apparently did not provide appropriate personnel and/or resources	0	0	0.00%
C13: Apparently did not order appropriate specialty consultations	0	0	0.00%
C14: Apparently specialty consultation process was not completed in a timely manner	0	0	0.00%
C15: Apparently did not effectively coordinate across disciplines	0	0	0.00%
C16: Apparently did not ensure a safe environment (medication errors, falls, pressure ulcers, transfusion reactions, nosocomial infection)	0	0	0.00%
C17: Apparently did not order/follow evidence-based practices	0	0	0.00%
C18: Apparently did not provide medical record documentation that impacts patient care	0	0	0.00%
C40: Apparently did not follow up on patient's non-compliance	0	0	0.00%
C99: Other quality concern not elsewhere classified	0	0	0.00%
Total	**3**	**1**	**33.33%**

5) Beneficiary Appeals of Provider Discharge/Service Terminations and Denials of Hospital Admissions Outcomes by Notification Type

Appeal Reviews by Notification Type	Number of Reviews	Percent of Total
Acute Appeals, FFS & Managed Care	76	81.72%
Medicare FFS Post-Acute Appeals	11	11.83%
Medicare Advantage Post-Acute Appeals	5	5.38%
Hospital Issued Notice of Non-Coverage Appeals	0	0.00%
Hospital Requested Review Appeals	1	1.08%
Total	**93**	**100.00%**

6) Reviews by Geographic Area – Urban and Rural

Table 6A: Appeal Reviews by Geographic Area – Urban and Rural

Geographic Area	Number of Providers	Percent of Providers in State
Urban	12	12.00%
Rural	84	84.00%
Unknown	4	4.00%
Total	**100**	**100.00%**

Table 6B: Quality of Care Reviews by Geographic Area – Urban and Rural

Geographic Area	Number of Providers	Percent of Providers in State
Urban	0	0.00%
Rural	3	100.00%
Unknown	0	0.00%
Total	**3**	**100.00%**

7) Immediate Advocacy Cases

Number of Beneficiary Complaints	Number of Immediate Advocacy Cases	Percent of Total Beneficiary Complaints Resolved by Immediate Advocacy
11	11	100.00%

ACENTRA BFCC-QIO REGION 10 – STATE OF IDAHO

1) TOTAL NUMBER OF REVIEWS

Review Type	Number of Reviews	Percent of Total Reviews
Acute Appeals, FFS & Managed Care	203	13.57%
Medicare FFS Post-Acute Appeals	119	7.95%
Medicare Advantage Post-Acute Appeals	1,044	69.79%
Hospital Issued Notice of Non-Coverage Appeals	47	3.14%
Hospital Requested Review Appeals	1	0.07%
Quality of Care	19	1.27%
Immediate Advocacy	38	2.54%
EMTALA	25	1.67%
Total	**1,496**	**100.00%**

2) BENEFICIARY DEMOGRAPHICS

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Sex/Gender		
Female	966	61.69%
Male	600	38.31%
Unknown	0	0.00%
Total	**1,566**	**100.00%**
Race		
Asian	15	0.96%
Black	17	1.09%
Hispanic	13	0.83%
North American Native	7	0.45%
Other	12	0.77%
Unknown	8	0.51%
White	1,494	95.40%
Total	**1,566**	**100.00%**
Age		
Under 65	196	12.52%
65-70	220	14.05%
71-80	473	30.20%
81-90	520	33.21%
91+	157	10.03%
Total	**1,566**	**100.00%**

3) PROVIDER REVIEWS SETTINGS

Setting	Number of Providers	Percent of Providers
0: Acute Care Unit of an Inpatient Facility	152	10.82%
1: Distinct Psychiatric Facility	5	0.36%
2: Distinct Rehabilitation Facility	78	5.55%
3: Distinct Skilled Nursing Facility	1,147	81.64%
5: Clinic	0	0.00%
6: Distinct Dialysis Center Facility	0	0.00%
7: Dialysis Center Unit of Inpatient Facility	0	0.00%
8: Independent-Based Rural Health Clinic	0	0.00%
9: Provider-Based Rural Health Clinic	0	0.00%
C: Freestanding Ambulatory Surgery Center	0	0.00%
G: End-Stage Renal Disease Unit	0	0.00%
H: Home Health Agency	3	0.21%
N: Critical Access Hospital	11	0.78%
O: Setting Does Not Fit Into Any Other Existing Setting Dode	0	0.00%
Q: Long-Term Care Facility	1	0.07%
R: Hospice	5	0.36%
S: Psychiatric Unit of an Inpatient Facility	0	0.00%
T: Rehabilitation Unit of an Inpatient Facility	2	0.14%
U: Swing Bed Hospital Designation for Short-Term, Long-Term Care, and Rehabilitation Hospitals	0	0.00%
Y: Federally Qualified Health Centers	0	0.00%
Z: Swing Bed Designation for Critical Access Hospitals	0	0.00%
Other	1	0.07%
Total	**1,405**	**100.00%**

4) QUALITY OF CARE CONCERNS CONFIRMED

A Quality of Care review is conducted by the BFCC-QIO to determine whether the quality of services provided to beneficiaries was consistent with professionally recognized standards of health care. A Quality of Care review can either be initiated by a Medicare beneficiary or his/her appointed representative or referred to the BFCC-QIO from another agency such as the Office of Medicare Ombudsmen and/or Congress, etc.

Acentra Health, in keeping with CMS directions, has referred all confirmed Quality of Care concerns, which appear to be systemic in nature and appropriate for quality improvement activities, to the appropriate Quality Innovation Network QIO (QIN-QIO) for follow-up. For confirmed concerns that may be amenable to a different approach to health care or related documentation, Acentra Health retained those concerns and worked directly with the health care provider and/or practitioner. The data below reflects the total number of concerns referred to the QIN-QIO and not those retained by Acentra Health in order to provide technical assistance.

Quality of Care ("C" Category) QRD Category Codes	Number of Concerns	Number of Concerns Confirmed	Percent Confirmed Concerns
C01: Apparently did not obtain pertinent history and/or findings from an examination	0	0	0.00%
C02: Apparently did not make appropriate diagnoses and/or assessments	4	0	0.00%
C03: Apparently did not establish and/or develop an appropriate treatment plan for a defined problem or diagnosis which prompted this episode of care [excludes laboratory and/or imaging (see C06 or C09), procedures (see C07 or C08) and consultations (see C13 and C14)]	12	6	50.00%
C04: Apparently did not carry out an established plan in a competent and/or timely fashion	10	2	20.00%
C05: Apparently did not appropriately assess and/or act on changes in clinical/other status results	0	0	0.00%
C06: Apparently did not appropriately assess and/or act on laboratory tests or imaging study results	0	0	0.00%
C07: Apparently did not establish adequate clinical justification for a procedure which carries patient risk and was performed	1	0	0.00%
C08: Apparently did not perform a procedure that was indicated (other than lab and imaging, see C09)	0	0	0.00%
C09: Apparently did not obtain appropriate laboratory tests and/or imaging studies	0	0	0.00%
C10: Apparently did not develop and initiate appropriate discharge, follow-up, and/or rehabilitation plans	0	0	0.00%
C11: Apparently did not demonstrate that the patient was ready for discharge	3	0	0.00%
C12: Apparently did not provide appropriate personnel and/or resources	0	0	0.00%
C13: Apparently did not order appropriate specialty consultations	0	0	0.00%
C14: Apparently specialty consultation process was not completed in a timely manner	0	0	0.00%
C15: Apparently did not effectively coordinate across disciplines	0	0	0.00%
C16: Apparently did not ensure a safe environment (medication errors, falls, pressure ulcers, transfusion reactions, nosocomial infection)	2	0	0.00%
C17: Apparently did not order/follow evidence-based practices	0	0	0.00%
C18: Apparently did not provide medical record documentation that impacts patient care	0	0	0.00%
C40: Apparently did not follow up on patient's non-compliance	0	0	0.00%
C99: Other quality concern not elsewhere classified	4	0	0.00%
Total	**36**	**8**	**22.22%**

5) Beneficiary Appeals of Provider Discharge/Service Terminations and Denials of Hospital Admissions Outcomes by Notification Type

Appeal Reviews by Notification Type	Number of Reviews	Percent of Total
Acute Appeals, FFS & Managed Care	203	14.36%
Medicare FFS Post-Acute Appeals	119	8.42%
Medicare Advantage Post-Acute Appeals	1,044	73.83%
Hospital Issued Notice of Non-Coverage Appeals	47	3.32%
Hospital Requested Review Appeals	1	0.07%
Total	**1,414**	**100.00%**

6) Reviews by Geographic Area – Urban and Rural

Table 6A: Appeal Reviews by Geographic Area – Urban and Rural

Geographic Area	Number of Providers	Percent of Providers in State
Urban	1,170	75.29%
Rural	171	11.00%
Unknown	213	13.71%
Total	**1,554**	**100.00%**

Table 6B: Quality of Care Reviews by Geographic Area – Urban and Rural

Geographic Area	Number of Providers	Percent of Providers in State
Urban	13	36.11%
Rural	14	38.89%
Unknown	9	25.00%
Total	**36**	**100.00%**

7) Immediate Advocacy Cases

Number of Beneficiary Complaints	Number of Immediate Advocacy Cases	Percent of Total Beneficiary Complaints Resolved by Immediate Advocacy
44	35	79.55%

ACENTRA BFCC-QIO REGION 10 – STATE OF OREGON

1) TOTAL NUMBER OF REVIEWS

Review Type	Number of Reviews	Percent of Total Reviews
Acute Appeals, FFS & Managed Care	739	15.23%
Medicare FFS Post-Acute Appeals	274	5.65%
Medicare Advantage Post-Acute Appeals	3,538	72.93%
Hospital Issued Notice of Non-Coverage Appeals	0	0.00%
Hospital Requested Review Appeals	0	0.00%
Quality of Care	62	1.28%
Immediate Advocacy	207	4.27%
EMTALA	31	0.64%
Total	**4,851**	**100.00%**

2) BENEFICIARY DEMOGRAPHICS

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Sex/Gender		
Female	2,258	61.78%
Male	1,397	38.22%
Unknown	0	0.00%
Total	**3,655**	**100.00%**
Race		
Asian	30	0.82%
Black	31	0.85%
Hispanic	26	0.71%
North American Native	13	0.36%
Other	24	0.66%
Unknown	16	0.44%
White	3,515	96.17%
Total	**3,655**	**100.00%**
Age		
Under 65	442	12.09%
65-70	490	13.41%
71-80	1,075	29.41%
81-90	1,239	33.90%
91+	409	11.19%
Total	**3,655**	**100.00%**

3) PROVIDER REVIEWS SETTINGS

Setting	Number of Providers	Percent of Providers
0: Acute Care Unit of an Inpatient Facility	698	15.55%
1: Distinct Psychiatric Facility	19	0.42%
2: Distinct Rehabilitation Facility	0	0.00%
3: Distinct Skilled Nursing Facility	3,587	79.91%
5: Clinic	0	0.00%
6: Distinct Dialysis Center Facility	0	0.00%
7: Dialysis Center Unit of Inpatient Facility	0	0.00%
8: Independent-Based Rural Health Clinic	3	0.07%
9: Provider-Based Rural Health Clinic	0	0.00%
C: Freestanding Ambulatory Surgery Center	1	0.02%
G: End-Stage Renal Disease Unit	1	0.02%
H: Home Health Agency	78	1.74%
N: Critical Access Hospital	63	1.40%
O: Setting Does Not Fit Into Any Other Existing Setting Code	0	0.00%
Q: Long-Term Care Facility	1	0.02%
R: Hospice	30	0.67%
S: Psychiatric Unit of an Inpatient Facility	0	0.00%
T: Rehabilitation Unit of an Inpatient Facility	0	0.00%
U: Swing Bed Hospital Designation for Short-Term, Long-Term Care, and Rehabilitation Hospitals	0	0.00%
Y: Federally Qualified Health Centers	0	0.00%
Z: Swing Bed Designation for Critical Access Hospitals	6	0.13%
Other	2	0.04%
Total	**4,489**	**100.00%**

4) QUALITY OF CARE CONCERNS CONFIRMED

A Quality of Care review is conducted by the BFCC-QIO to determine whether the quality of services provided to beneficiaries was consistent with professionally recognized standards of health care. A Quality of Care review can either be initiated by a Medicare beneficiary or his/her appointed representative or referred to the BFCC-QIO from another agency such as the Office of Medicare Ombudsmen and/or Congress, etc.

Acentra Health, in keeping with CMS directions, has referred all confirmed Quality of Care concerns, which appear to be systemic in nature and appropriate for quality improvement activities, to the appropriate Quality Innovation Network QIO (QIN-QIO) for follow-up. For confirmed concerns that may be amenable to a different approach to health care or related documentation, Acentra Health retained those concerns and worked directly with the health care provider and/or practitioner. The data below reflects the total number of concerns referred to the QIN-QIO and not those retained by Acentra Health in order to provide technical assistance.

Quality of Care ("C" Category) QRD Category Codes	Number of Concerns	Number of Concerns Confirmed	Percent Confirmed Concerns
C01: Apparently did not obtain pertinent history and/or findings from an examination	1	0	0.00%
C02: Apparently did not make appropriate diagnoses and/or assessments	4	0	0.00%
C03: Apparently did not establish and/or develop an appropriate treatment plan for a defined problem or diagnosis which prompted this episode of care [excludes laboratory and/or imaging (see C06 or C09), procedures (see C07 or C08) and consultations (see C13 and C14)]	38	6	15.79%
C04: Apparently did not carry out an established plan in a competent and/or timely fashion	15	4	26.67%
C05: Apparently did not appropriately assess and/or act on changes in clinical/other status results	3	0	0.00%
C06: Apparently did not appropriately assess and/or act on laboratory tests or imaging study results	3	0	0.00%
C07: Apparently did not establish adequate clinical justification for a procedure which carries patient risk and was performed	5	0	0.00%
C08: Apparently did not perform a procedure that was indicated (other than lab and imaging, see C09)	4	0	0.00%
C09: Apparently did not obtain appropriate laboratory tests and/or imaging studies	0	0	0.00%
C10: Apparently did not develop and initiate appropriate discharge, follow-up, and/or rehabilitation plans	3	1	33.33%
C11: Apparently did not demonstrate that the patient was ready for discharge	9	3	33.33%
C12: Apparently did not provide appropriate personnel and/or resources			
C13: Apparently did not order appropriate specialty consultation	1	0	0.00%
C14: Apparently specialty consultation process was not completed in a timely manner	1	1	100.00%
C15: Apparently did not effectively coordinate across disciplines	0	0	0.00%
C16: Apparently did not ensure a safe environment (medication errors, falls, pressure ulcers, transfusion reactions, nosocomial infection)	13	5	38.46%
C17: Apparently did not order/follow evidence-based practices	1	1	100.00%
C18: Apparently did not provide medical record documentation that impacts patient care	4	3	75.00%
C40: Apparently did not follow up on patient's non-compliance	0	0	0.00%
C99: Other quality concern not elsewhere classified	4	1	25.00%
Total	**109**	**25**	**22.94%**

5) Beneficiary Appeals of Provider Discharge/Service Terminations and Denials of Hospital Admissions Outcomes by Notification Type

Appeal Reviews by Notification Type	Number of Reviews	Percent of Total
Acute Appeals, FFS & Managed Care	739	16.24%
Medicare FFS Post-Acute Appeals	274	6.02%
Medicare Advantage Post-Acute Appeals	3,538	77.74%
Hospital Issued Notice of Non-Coverage Appeals	0	0.00%
Hospital Requested Review Appeals	0	0.00%
Total	**4,551**	**100.00%**

6) Reviews by Geographic Area – Urban and Rural

Table 6A: Appeal Reviews by Geographic Area – Urban and Rural

Geographic Area	Number of Providers	Percent of Providers in State
Urban	4,352	94.98%
Rural	11	0.24%
Unknown	219	4.78%
Total	**4,582**	**100.00%**

Table 6B: Quality of Care Reviews by Geographic Area – Urban and Rural

Geographic Area	Number of Providers	Percent of Providers in State
Urban	67	59.82%
Rural	0	0.00%
Unknown	45	40.18%
Total	**112**	**100.00%**

7) Immediate Advocacy Cases

Number of Beneficiary Complaints	Number of Immediate Advocacy Cases	Percent of Total Beneficiary Complaints Resolved by Immediate Advocacy
227	203	89.43%

ACENTRA BFCC-QIO REGION 10 – STATE OF WASHINGTON

1) TOTAL NUMBER OF REVIEWS

Review Type	Number of Reviews	Percent of Total Reviews
Acute Appeals, FFS & Managed Care	1,099	9.94%
Medicare FFS Post-Acute Appeals	898	8.12%
Medicare Advantage Post-Acute Appeals	8,616	77.95%
Hospital Issued Notice of Non-Coverage Appeals	4	0.04%
Hospital Requested Review Appeals	36	0.33%
Quality of Care	99	0.90%
Immediate Advocacy	283	2.56%
EMTALA	18	0.16%
Total	**11,053**	**100.00%**

2) BENEFICIARY DEMOGRAPHICS

Demographics	Number of Beneficiaries	Percent of Beneficiaries
Sex/Gender		
Female	8,187	64.20%
Male	4,566	35.80%
Unknown	0	0.00%
Total	**12,753**	**100.00%**
Race		
Asian	134	1.05%
Black	332	2.60%
Hispanic	88	0.69%
North American Native	122	0.96%
Other	130	1.02%
Unknown	100	0.78%
White	11,847	92.90%
Total	**12,753**	**100.00%**
Age		
Under 65	1,522	11.93%
65-70	1,450	11.37%
71-80	4,111	32.24%
81-90	4,126	32.35%
91+	1,544	12.11%
Total	**12,753**	**100.00%**

3) PROVIDER REVIEWS SETTINGS

Setting	Number of Providers	Percent of Providers
0: Acute Care Unit of an Inpatient Facility	965	9.19%
1: Distinct Psychiatric Facility	1	0.01%
2: Distinct Rehabilitation Facility	28	0.27%
3: Distinct Skilled Nursing Facility	9,182	87.48%
5: Clinic	0	0.00%
6: Distinct Dialysis Center Facility	0	0.00%
7: Dialysis Center Unit of Inpatient Facility	0	0.00%
8: Independent-Based Rural Health Clinic	0	0.00%
9: Provider-Based Rural Health Clinic	0	0.00%
C: Freestanding Ambulatory Surgery Center	0	0.00%
G: End-Stage Renal Disease Unit	0	0.00%
H: Home Health Agency	100	0.95%
N: Critical Access Hospital	95	0.91%
O: Setting Does Not Fit Into Any Other Existing Setting Code	41	0.39%
Q: Long-Term Care Facility	2	0.02%
R: Hospice	28	0.27%
S: Psychiatric Unit of an Inpatient Facility	0	0.00%
T: Rehabilitation Unit of an Inpatient Facility	26	0.25%
U: Swing Bed Hospital Designation for Short-Term, Long-Term Care, and Rehabilitation Hospitals	0	0.00%
Y: Federally Qualified Health Centers	0	0.00%
Z: Swing Bed Designation for Critical Access Hospitals	24	0.23%
Other	4	0.04%
Total	**10,496**	**100.00%**

4) QUALITY OF CARE CONCERNS CONFIRMED

A Quality of Care review is conducted by the BFCC-QIO to determine whether the quality of services provided to beneficiaries was consistent with professionally recognized standards of health care. A Quality of Care review can either be initiated by a Medicare beneficiary or his/her appointed representative or referred to the BFCC-QIO from another agency such as the Office of Medicare Ombudsmen and/or Congress, etc.

Acentra Health, in keeping with CMS directions, has referred all confirmed Quality of Care concerns, which appear to be systemic in nature and appropriate for quality improvement activities, to the appropriate Quality Innovation Network QIO (QIN-QIO) for follow-up. For confirmed concerns that may be amenable to a different approach to health care or related documentation, Acentra Health retained those concerns and worked directly with the health care provider and/or practitioner. The data below reflects the total number of concerns referred to the QIN-QIO and not those retained by Acentra Health in order to provide technical assistance.

Quality of Care ("C" Category) QRD Category Codes	Number of Concerns	Number of Concerns Confirmed	Percent Confirmed Concerns
C01: Apparently did not obtain pertinent history and/or findings from an examination	1	0	0.00%
C02: Apparently did not make appropriate diagnoses and/or assessments	10	6	60.00%
C03: Apparently did not establish and/or develop an appropriate treatment plan for a defined problem or diagnosis which prompted this episode of care [excludes laboratory and/or imaging (see C06 or C09), procedures (see C07 or C08) and consultations (see C13 and C14)]	58	6	10.34%
C04: Apparently did not carry out an established plan in a competent and/or timely fashion	33	2	6.06%
C05: Apparently did not appropriately assess and/or act on changes in clinical/other status results	1	0	0.00%
C06: Apparently did not appropriately assess and/or act on laboratory tests or imaging study results	0	0	0.00%
C07: Apparently did not establish adequate clinical justification for a procedure which carries patient risk and was performed	1	0	0.00%
C08: Apparently did not perform a procedure that was indicated (other than lab and imaging, see C09)	3	2	66.67%
C09: Apparently did not obtain appropriate laboratory tests and/or imaging studies	2	2	100.00%
C10: Apparently did not develop and initiate appropriate discharge, follow-up, and/or rehabilitation plans	9	3	33.33%
C11: Apparently did not demonstrate that the patient was ready for discharge	12	0	0.00%
C12: Apparently did not provide appropriate personnel and/or resources	0	0	0.00%
C13: Apparently did not order appropriate specialty consultations	1	0	0.00%
C14: Apparently specialty consultation process was not completed in a timely manner	0	0	0.00%
C15: Apparently did not effectively coordinate across disciplines	5	0	0.00%
C16: Apparently did not ensure a safe environment (medication errors, falls, pressure ulcers, transfusion reactions, nosocomial infection)	13	2	15.38%
C17: Apparently did not order/follow evidence-based practices	2	0	0.00%
C18: Apparently did not provide medical record documentation that impacts patient care	0	0	0.00%
C40: Apparently did not follow up on patient's non-compliance	0	0	0.00%
C99: Other quality concern not elsewhere classified	11	2	18.18%
Total	**162**	**25**	**15.43%**

5) Beneficiary Appeals of Provider Discharge/Service Terminations and Denials of Hospital Admissions Outcomes by Notification Type

Appeal Reviews by Notification Type	Number of Reviews	Percent of Total
Acute Appeals, FFS & Managed Care	1,099	10.32%
Medicare FFS Post-Acute Appeals	898	8.43%
Medicare Advantage Post-Acute Appeals	8,616	80.88%
Hospital Issued Notice of Non-Coverage Appeals	4	0.04%
Hospital Requested Review Appeals	36	0.34%
Total	**10,653**	**100.00%**

6) Reviews by Geographic Area – Urban and Rural

Table 6A: Appeal Reviews by Geographic Area – Urban and Rural

Geographic Area	Number of Providers	Percent of Providers in State
Urban	10,537	94.71%
Rural	46	0.41%
Unknown	542	4.87%
Total	**11,125**	**100.00%**

Table 6B: Quality of Care Reviews by Geographic Area – Urban and Rural

Geographic Area	Number of Providers	Percent of Providers in State
Urban	158	74.88%
Rural	3	1.42%
Unknown	50	23.70%
Total	**211**	**100.00%**

7) Immediate Advocacy Cases

Number of Beneficiary Complaints	Number of Immediate Advocacy Cases	Percent of Total Beneficiary Complaints Resolved by Immediate Advocacy
322	275	85.40%

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